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ABSTRACT

The use of hypnosis in a pediatric setting has the potential for yielding effective results. Obstacles to its use are inappropriate training of psychologists in pediatric psychology, resistance to hypnosis from the pediatricians and mental health professionals, fragmented communication, and constant demand for space and time. Success of hypnosis for the individual patient in a clinical situation depends on strong motivation and expectations, a positive relationship with the therapist, and trance ability. Successful use of hypnosis in pediatric care requires a strong desire for using hypnosis, positive collaboration with the pediatricians, and credibility in using hypnosis. In one pediatric hospital setting, hypnosis was used in about five percent of the referrals. Four symptom areas are particularly conducive to the use of hypnosis: (1) pain and discomfort; (2) anxiety and phobic disorders; (3) undesirable habits; and (4) other physical symptoms. Five signs of established credibility include earlier referrals, clearer professional communication, more requests for educational experiences, less checking out of the psychologists, and more informal inquiries regarding hypnosis. Maintaining credibility can be helped by staying visible, continuing educational efforts with the pediatricians, keeping abreast of current demand in subspecialty areas, facilitating the pediatrician's preparation of patients for referral, and preventing psychologist burnout by keeping responsibility in line with interests. Maintaining autonomy as much as possible seems essential for the effective use of hypnosis. (ABL)

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Use of Hypnosis by Psychologists in a Pediatric Setting: Establishing and Maintaining Credibility

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Use of Hypnosis by Psychologists in a Pediatric Setting:

Establishing and Maintaining Credibility

Donald J. O'Grady, Ph.D. and Claudia Hoffmann, Ed.D.

~~A~~ I have subtitled ~~for~~ this paper ~~would be~~ "Establishing and maintaining credibility", in that, I am not going to focus on how to use hypnosis with children. Rather the purpose of this paper is to share my experiences as a psychologist in the pediatric setting in developing a view of hypnosis as a valuable asset in pediatric care.

The stimulus for this discussion came from my observations that it has been much easier to introduce and establish hypnosis as a worthwhile alternative or supplementary treatment with the patients and their families than their pediatricians. Excellent discussions to help the psychologist use hypnosis with a variety of childhood problems are readily available (See Gardner and Olness, 1981; Hilgard and LeBaron, 1985; O'Grady and Hoffmann, 1984). Discussions of the particular problems of the psychologist using hypnosis in the medical setting are hard to find.

First, let me briefly describe the setting in which I work. Children's Hospital Medical Center in Cincinnati, Ohio is a 350 bed facility, on of the busiest in the country. It is the home of the Department of Pediatrics of the University of Cincinnati College of Medicine. There are 85 full-time faculty of which 18 are Ph.D. basic scientists. Sabin developed the oral vaccine for Polio there and over 200 publications are produced each year. The production of research protocols that are not only scientifically sound, but able to attract external grants is highly valued to say the least.

Our pediatric psychology department was established in 1973 and 'was merged' in 1979 with psychiatry into the department of child psychiatry and psychology. There are four psychologists and two bachelor level psychology technicians. We receive referrals from the inpatient service, including a recently established 8 bed, school age psychiatric unit, from the general medical clinic, specialty clinics and private pediatricians. Historically, our strongest collaboration has developed out of my work with PKU, Cystic Fibrosis, and Neurology. (It's often difficult to understand the 'politics of referral' without knowing the underlying history in institutions.) These early ties have been most helpful in establishing and maintaining credibility as a psychologist who happens to use hypnosis at times. There have been, however, many obstacles to collaboration.

Obstacles to collaboration

In addition to the usual resistance to hypnosis from mental health and health professionals, the psychologist attempting to introduce hypnosis into the pediatric setting, has to do so in the unfamiliar university hospital culture. Drotar (1982) in a chapter on "the child psychologist in the medical setting" describes knowingly the difficulties of being a "guest in the family home" of medicine and, specifically, pediatrics.

Besides the unfamilar work environment and hospital culture, Drotar also noted the limited training most of us had in pediatric psychology, often including an emphasis on psychopathology rather than on coping models. In contrast, pediatricians do not view

many of their referred patients as having psychopathology, but rather as showing symptoms of stress for which they would like us to provide relief and comfort. Hypnosis as an adjunctive and symptomatic treatment has become a vehicle for overcoming the obstacle to collaboration presented by our different orientations.

Other obstacles noted by Drotar, such as the high specialization and resulting fragmented communication regarding the patient, the constant demand for space and time and the different professional traditions, all have particular impact on establishing and maintaining hypnosis in the medical setting. The tradition of primary medical authority and responsibility may lead to referrals for use of hypnosis without knowledge of how it works. For example, referrals for hypnosis late in the course of a terminal illness or shortly before hospital discharge reflect the lack of understanding of how hypnosis works. The pediatric psychologist may find him or herself helping the pediatrician or resident 'save face' by accepting the referral without many questions. Hypnosis in these cases may never be used. Later, the psychologist works on negotiating more informed referrals.

Over the years in our setting, we have learned to identify and search for practice areas in the hospital where the essential ingredients for successful use of hypnosis are present.

Essentials for effective hypnosis in the clinical situation

Shor suggested that the success of hypnosis for the individual patient in the clinical situation depends on (1) strong motivation and expectations (2) a positive relationship with the therapist and (3) trance ability. It might also be said that the success of hypnosis for the psychologist in the pediatric setting could be viewed from the same perspective. In other words the successful introduction, establishment, and maintenance of hypnosis as a technique used in pediatric care depends on 3 similar factors.

First, the psychologist needs to identify those practice areas in their setting where there is a strong desire for using techniques such as hypnosis. Assuming what is best for the pediatric subspecialist is hazardous. For example, we at CHMC/Psychology felt that relief from the distress of BMAs and spinal taps was a high priority - Wrong - the pediatric oncologists were much more distressed with the problem of anticipatory and prolonged nausea and vomiting related to chemotherapy; in part, because the nurses did most of the BMAs and the anticipatory nausea and vomiting frequently led to complications and, at times, to refusal of treatment. So what influences the motivation of the Pediatrician?

In our setting the motivation has come from (1) patients hearing about and requesting hypnosis (2) readiness to try anything that might help with their most troublesome symptoms e.g. nausea and vomiting associated with chemotherapy, continued

ticcing in spite of Haldol, phobic reactions in the dental area and (3) peer pressure from other institutions where hypnosis may be routinely used. We have taken these opportunities and developed them.

Secondly, the psychologist needs to have developed a positive collaborative relationship with the pediatricians, where there is mutual respect, before hypnotherapy is readily accepted as a possible treatment option for their patients. It was not surprising, therefore, that we were first able to introduce hypnosis as an alternative and supplementary treatment in specialty areas where we had a long history of offering valued services. In our situation, pediatric neurology and dentistry sections offered the first opportunities. The pediatric dentists knew us from our work in screening, assessment and psychotherapy with children and adolescents with cranio-facial anomalies. It was relatively easy to suggest to them the possible benefits of hypnosis for their more fearful patients. Neurology knew us through our work with developmentally disabled children and adolescents, including psychotherapeutic work with their more complicated families with seizure disorders. Referrals of children with 'transient tics' began, followed by cases with Tourette Syndrome with tics inadequately controlled with medication, and then patients with headaches. Initially, referrals did not specifically request hypnosis, but the past positive relationship with neurology allowed us to suggest hypnosis as a viable technique in addition to the behavioral techniques we had already been using.

There are other examples illustrating the importance of the

positive relationship, such as with G.I. where our long collaboration on Reye Syndrome led to referrals of problems more likely relieved by hypnosis. Problems commonly referred for possible hypnosis are irritable bowel syndrome, recurrent abdominal pain, pain related to chronic pancreatitis, and other bowel disorders.

However, the importance of the relationship is also strongly illustrated by the <u>difficulties</u> in using hypnosis in areas where we have not had such a positive history. With hematology/oncology, for example, a 20 year old patient with leukemia undergoing repeated BMAs and spinal taps asked his private psychiatrist if he knew of anyone who used hypnosis as he had seen discussed on 'Phil Donahue's Show'. The psychiatrist referred him to one of his colleagues in the local hypnosis society, who then gave the patient our names, back at Children's . The patient's oncologist called asking for help for his patient's fears and worries regarding the painful procedures - he did not use the term 'hypnosis' until I mentioned it as a possibility. In our early days with hematology/oncology we discovered that we were periodically checked out via psychiatry as to their thoughts about the credibility of hypnosis. Once we developed a collaborative relationship, not only around the use of hypnosis, but also in areas of neuropsychology and psychosocial assessment of families, the referral for possible hypnotherapy became more common as well as "open" i.e. labelled as referral for "hypnosis".

The third factor is the credibility of the psychologist as a hypnotherapist, specifically. Establishing one's ability to use hypnosis effectively depends on the psychologist's identification

of the hierachy of values in one's particular medical setting. In our setting the presenting problems must be of concern to academic pediatricians, the psychologist must be able to demonstrate the ability to analyze the scientific literature, to measure phenomena, to produce publishable material, and to generate research protocols acceptable to our human investigations committee. In this context, we discovered early that credibility dramatically increased when we developed protocols, including measurements of hypnotic responsiveness, for treating (1) tics of Tourette Syyndrome, (2) pain related to Sickle Cell Anemia (3) anticipatory nausea and vomiting related to cancer chemotherapy and (4) pain and discomfort related to bone marrow aspirations. The protocols not only demonstrated our knowledge of hypnosis, but also showed our willingness to play by the implicit rules of our academic pediatric setting. A number of the protocols led to collaborative grant proposals with pediatric subspecialties.

Finally, teaching pediatric residents is highly valued and we spend much effort doing so. Lectures, reading materials, opportunities for observation, videotapes, and articles in our 'Round the Center' (slide) have helped establish our credibility.

Current Uses

It seems important to indicate that hypnosis was used in only about 5% or 38 of 757 of our referrals last year, again reflecting the context in which we use it. We try to emphasize that we do not specialize in a technique such as hypnosis, but that we 'specialize' in treating certain conditions some of which seem to

respond to hypnosis.

Currently, there are four symptom areas where we use hypnosis: (1) Pain and discomfort (2) Anxiety and phobic disorders (3) Undesirable habits (4) Other physical symptoms. These four symptom areas cut across pediatric specialties as seen in the accompanying table.

Our presentation of hypnosis to the individual child or adolescent and his/her parents is described more fully elsewhere (O'Grady and Hoffmann, 1984). However, in the context of establishing and maintaining credibility, two aspects of our approach, although not unique, need to be emphasized. First, preparation of the patient and parents always uses the word 'hypnosis' as one technique that the pediatrician thought might be helpful. Thus, if there is miscommunication as to what the problem is and what treatment is needed, it can be clarified early. Sometimes the pediatrician will communicate too little, e.g. by expecting hypnosis from the psychologist but not telling the patient or family. At other times, too much is communicated e.g. by telling the patient and family that hypnosis is <u>the</u> treatment for the problem. Fortunately, the miscommunications have decreased due to our continuing educational efforts.

A second aspect of our approach, i.e. routine measurement of hypnotic responsiveness with the Stanford Clinical Scales for adults and children also helps to communicate our view of hypnosis as a phenomenon that is subject to scientific evaluation and <u>not</u> equally useful to all patients.

A review of our experiences in the pediatric setting suggests that there are signs indicating the establishment of hypnosis as a

credible technique.

Signs of Established Credibility

These five signs (see table) include 1) earlier referrals e.g. of an anxious cancer patient beginning chemotherapy, 2) clearer professional communication, e.g. using the word "hypnosis" with the family and being clear that they are making a referral, 3) more requests for educational experiences, e.g. invitations to present at resident conferences, nursing grand rounds etc., 4) less "checking us out with other 'members of the family' i.e. psychiatry, and finally 5) more informal inquiries regarding possible use of hypnosis for the health professionals themselves or friends and relatives.

Unfortunately, just as children who have learned self-hypnosis sometimes do not maintain use of it, the physicians do not always maintain their motivation to use it for their patients without efforts on the psychologist's part.

Maintaining Credibility or "So what have you done for me lately"

Some ways we have found helpful in maintaining credibility include: staying visible not only in doing hypnotherapy, but in being available to offer comprehensive psychological services, continuing educational efforts regarding possibilities and limitations (getting time in the tight pediatric resident's schedule is an ongoing struggle), keeping abreast of current

demands in subspecialty areas e.g. in working with neurology we became aware that their interest in tics was waning and many more patients with difficult to manage headaches were being referred to them. By identifying and responding to this shift, collaboration was maintained. Facilitating the pediatrician's preparation of patients for referral for possible hypnotherapy also seems to be helpful as a maintenance strategy: Providing brochures to the pediatrician and offering to explain the procedures to the family can be helpful. Again, it is an ongoing task due to resident and faculty turnover. Finally, preventing the psychologist's 'burnout' in using hypnosis is very important. It doesn't take long to feel overloaded e.g. by the demands of repeated cases of anticipatory and prolonged nausea and vomiting in terminally ill children and adolescents.

Drotar (1982) suggested some strategies for preventing burnout in this setting and they apply well to the specialized area of hypnotherapy. The psychologist needs to constantly keep the direction of professional responsibility in line with his or her own interests. Otherwise, one quickly feels that his or her priorities are unimportant. Selectivity of subspecialty areas is also important. As Drotar suggests, one looks for "congenial collaborators" who are interested in "sharing decision making". The last strategy for maintaining oneself as a hypnotherapist in the pediatric setting is to make efforts to develop independent of any one subspecialty area. One needs to share experiences with colleagues in psychology. We are still "guests in the house" and maintaining our autonomy as much as possible seems essential for the psychologist's effective use of hypnosis in this setting.

Summary

In summary, because we have found hypnosis be to a highly valuable technique for providing relief and comfort to children and their parents, we have learned the importance of identifying strategies that, not only establish, but maintain the credibility of hypnosis as a powerful ? alternative and supplementary technique in the treatment of pediatric problems. We hope that others will share their strategies in dealing with the obstacles for psychologists using hypnosis in their pediatric setting.

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'Round the Center

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Hypnosis: powerful tool for pain, anxiety control

The same vivid imagination that made Melissa York ill just thinking about her chemotherapy treatment also has helped her cope with it.

Merely reading a birthday card sent her by Children's staff would cause 20-year-old Melissa, a cancer patient here, to vomit.

She would start vomiting two weeks before a scheduled treatment. And she'd be ill during the whole five-hour trip from her home in Phyllis, Kentucky.

Self-hypnosis, taught her by Dr. Claudia Hoffmann, staff psychologist at CHMC, has made all the difference.

Now, Melissa can think about treatments without getting ill. For the first time, she also is able to talk about her disease with family and friends.

"Hypnosis is learning to imagine so vividly with the help of a therapist that what you imagine seems real," says Dr. Donald O'Grady, director of psychology services at CHMC.

The ice block melts

"One teenager had great pain with bone marrow aspirations," Dr. O'Grady says. "He described the pain as an ice pick stabbing a block of ice. Through hypnosis, he was able to imagine the block of ice as melted. The pain he felt then was greatly lessened."

Hypnosis has been used for more than 200 years to aid in treating children. The technique has been revived in recent years, and has been in use at Children's since 1977.

Since then, about 100 of our patients have been taught self-hypnosis. They can reduce the pain and fear of having such procedures as bone marrow aspirations, spinal taps and IV starts.

Hypnosis also has helped children manage habit disorders, such as bedwetting and nervous tics, and to control anxiety, such as in school or needle phobias.

Highway hypnosis

"Hypnotic responsiveness is inherent in everyone to some degree," Dr. O'Grady says. "If you've found yourself lost in thought as you're driving on the highway, you've experienced a form of hypnosis."

Before a patient is taught the technique at Children's, he takes a special test to gauge hypnotic responsiveness.

A psychologist then teaches him how to induce hypnosis. One method in-

Essentials for Successful Hypnosis

Strong Motivation

Positive Relationship

Trance Ability

Symptoms by Subspecialty Areas

1. Pain and Discomfort

- Hematology/Oncology
  - Sickle Cell Anemia
  - Hemophilia
  - Cancer
- Gastroenterology
  - Irritable Bowel Syndrome
  - Recurrent Abdominal Pain
  - Chronic Pancreatitis
  - Pseudo-obstructive bowel disorder
- Neurology
  - Headaches
- Dentistry
  - (Surgery)
  - (Rheumatology)

2. Anxiety

   Hematology/Oncology

   Dentistry

   Surgery

   Endocrinology (Juvenile Diabetes)

   Psychiatry

3. Undesirable Habits

   Urology (enuresis)

   Gastroenterology (encopresis)

   Neurology (tics)

   Dermatology (Scratching)

4. Other physical symptoms with learned component

   Hematology/Oncology (Anticipatory, delayed and prolonged nausea and vomiting)

   Gastroenterology (psychogenic vomiting, eating disturbances)

   Neurology (tremor, pseudoseizures)

Signs of Established Credibility

- Earlier Referrals
- Clearer Professional Communication
- More Requests for Educational Experiences
- Less "checking us out" with psychiatry
- More informal inquiries regarding hypnosis for significant others

Maintaining Credibility

- Staying Visible
- Continuing Educational efforts regarding Possibilities and Limitations
- Keeping abreast of current demands in Subspecialty area
- Facilitating pediatrician's preparation of patients for hypnosis
- Preventing psychologist's "burnout" in using hypnosis in the setting